



05420700

See detailed instructions on page 2. Please type or print.

SERVICE- RECIPIENT (BUSINESS OR GOVERNMENT ENTITY):

DATE										FEDERAL ID NO.										CA EMPLOYER ACCOUNT NO.										SOCIAL SECURITY NO.										NO. OF FORMS NEEDED									
M M D D Y Y																																																	
SERVICE-RECIPIENT NAME / BUSINESS NAME																														CONTACT PERSON																			
ADDRESS																									TELEPHONE NO.																								
CITY																									STATE					ZIP																			

SERVICE-PROVIDER (INDEPENDENT CONTRACTOR):

FIRST NAME										MI	LAST NAME																			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>										
SOCIAL SECURITY NO.																														
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																					
START DATE OF CONTRACT										AMOUNT OF CONTRACT										CONTRACT EXPIRATION DATE										CHECK HERE IF CONTRACT IS ONGOING
M	M	D	D	Y	Y					<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	M	M	D	D	Y	Y					<input type="checkbox"/>

FIRST NAME										MI	LAST NAME									

SOCIAL SECURITY NO.

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START DATE OF CONTRACT						AMOUNT OF CONTRACT						CONTRACT EXPIRATION DATE						CHECK HERE IF CONTRACT IS ONGOING				
M	M	D	D	Y	Y											M	M	D	D	Y	Y	<input type="checkbox"/>

FIRST NAME										MI		LAST NAME																			
SOCIAL SECURITY NO.																															
START DATE OF CONTRACT										AMOUNT OF CONTRACT										CONTRACT EXPIRATION DATE										CHECK HERE IF CONTRACT IS ONGOING	
M M D D Y Y										M M D D Y Y .										M M D D Y Y											

INSTRUCTIONS FOR COMPLETING THE REPORT OF INDEPENDENT CONTRACTOR(S)

WHO MUST REPORT:

Any business or government entity (defined as a "service-recipient") that is required to file a Federal Form 1099-MISC for service performed by an independent contractor (defined as a "service-provider") must report. You must report to the Employment Development Department within twenty (20) days of EITHER making payments of six hundred dollars (\$600) or more OR entering into a contract for \$600 or more with an independent contractor in any calendar year, whichever is earlier. This information is used to assist state and county agencies in locating parents who are delinquent in their child support obligations.

An independent contractor is further defined as an individual who is not an employee of the business or government entity for California purposes and who receives compensation or executes a contract for services performed for that business or government entity either in or outside of California. For further clarification, request *Information Sheet: Employment Work Status Determination* (DE 231ES). See below for additional information on how to obtain forms.

YOU ARE REQUIRED TO PROVIDE THE FOLLOWING INFORMATION THAT APPLIES:

Service-Recipient (Business or Government Entity):

- Federal employer identification number
- CA employer account number
- Social security number
- Service-recipient name/business name, address, and telephone number.

Service-Provider (Independent Contractor):

- First name, middle initial, and last name
- Social security number
- Start date of contract OR date payments equal \$600 or more
- Amount of contract (including cents)
- Contract expiration date

HOW TO COMPLETE THIS FORM:

If you use a typewriter or printer, ignore the boxes and type in UPPER CASE as shown. Do not use commas or periods.

FIRST NAME	MI	LAST NAME
IMOGENE	A	SAMPLE
SOCIAL SECURITY NO.		
123456789		

If you **handwrite this form**, print each letter or number in a separate box as shown. Do not use commas or periods.

FIRST NAME	MI	LAST NAME
I M O G E N E	A	S A M P L E
SOCIAL SECURITY NO.		
1 2 3 4 5 6 7 8 9		

GENERAL INFORMATION:

If you have any questions concerning this reporting requirement, please call (916) 657-0529. You may also contact your local Employment Tax Customer Service Office listed in your telephone directory in the State Government section under "Employment Development Department." Or you may access our Internet site at www.edd.ca.gov.

To obtain information for submitting *Report of Independent Contractor(s)* on magnetic media, call (916) 651-6945.

To obtain additional DE 542 forms:

- Enter number of forms needed in upper right hand corner on front of form, or
- Visit our Internet site at www.edd.ca.gov, or
- For 25 or less forms, telephone (916) 657-0529, or
- For more than 25 forms, telephone (916) 322-2835

HOW TO REPORT:

Please record the information in the spaces provided and mail to the following address or fax to (916) 255-3211:

EMPLOYMENT DEVELOPMENT DEPARTMENT
P. O. Box 997350, MIC 99
Sacramento, CA 95899-7350